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Letters

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Consultants' new contract

Shurely shome mishtake?

EDITOR—I think that there must be a mistake and I have downloaded the wrong contract from the BMA's website.¹ The one I downloaded offers a 4% pay rise in return for a 16% increase in my clinical workload. Further pay rises are at the whim of my managers, to be paid five years in arrears provided that I meet conditions over which I have no control or work unpaid overtime.

The contract I downloaded is a licence to enable my managers to order me in for routine surgery and clinics on weekday evenings, Saturdays, and Sundays, for no extra pay, while paying me £1 an hour to be on-call at other times. Could someone please send me the other contract that Peter Hawker and the BMA are hailing as a resounding victory for my colleagues and me² while I vote no to what is clearly a different contract.

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1 Consultant contract: framework. Available at: www.bma.org.uk/apnsf/Content/_Hub+csc+contract (accessed 3 July 2002).

2 Hargreaves S. Government makes U turn on private practice ban. *BMJ* 2002;324:1473. (22 June.)

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We prefer to receive all responses electronically, sent directly to our website. Processing your letter will be delayed unless it arrives in an electronic form.

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So called victory in private practice obscures real contractual problems

EDITOR—Reports on the proposed consultant contract have focused too heavily on the concessions obtained over private practice and the headline figure of a 20% pay rise.¹ The pitfalls of the contract far outweigh this victory.

Firstly, few doctors will immediately, or in the near future, get a 20% rise in pay. Essentially we are being promised a 20% rise staged over 20 years, or 1% a year. For many this rise will be offset in part by loss of domiciliary fees, category 2 work, and the loss of intensity payments. My own pay rise will be 2-3%—hardly a princely sum given I work full time for the NHS.

Secondly, the new contract seeks to make evening working up to 10 pm and weekend morning work an acceptable part of the working week, remunerable at standard rate. I find this appalling. Junior doctors have spent years fighting to be remunerated at above the standard rate for working unsociable hours. Should it be any different for consultants? And if the aim is to keep people in hospital medicine why pursue such family unfriendly initiatives?

Thirdly, too much control is being handed to managers—both in terms of when work is done and when salary increments are paid. The new salary introduces two forms of performance related pay: the revamped merit award scheme and the basic pay spine. Didn't the BMA fight a long campaign against performance related pay a few years ago? What happened?

The contract does not fulfil any of its core objectives. I now feel undervalued by my employer and my trade union. I want to retire even earlier. I think a no vote can be taken as read.

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1 Hargreaves S. Government makes U turn on private practice ban. *BMJ* 2002;324:1473. (22 June.)

Private practice is unlikely to be main cause of long waiting lists

EDITOR—The new consultant contract introduces job plans for hospital consultants' Full time consultants are to have a working week made up of 10 "programmed activities" of "typically four hours each," seven of which will be "devoted to direct

clinical care." The contract also states that "NHS consultants' commitment to the NHS must take priority over any work undertaken for other organisations." The clear implication is that consultants, because of their perceived focus on earning private income, are at least one of the causes of inefficiency and long waiting times, particularly for elective surgery.

In November and December 1997 we carried out a prospective audit of all elective general, vascular, urological and breast procedures in patients scheduled for preoperative assessment or admission to Southampton University hospitals to establish the proportion of operations cancelled and for what reasons. There were no red alerts during this time.

Of the 851 patients identified, 847 (99.5%) had data available. Of these, 106 (12.5%) received urgent planned admissions, the remainder being asked to attend a preoperative assessment clinic. Of these, 61 (8.2%) did not attend. Of those who did attend, 30 (4%) had their procedures postponed or abandoned, 22 because of medical problems and eight because of social problems or patient preference.

Altogether, 756 patients were scheduled for admission, including those receiving urgent planned admission. Of these, 123 (16.3%) had their operations cancelled before admission, and three failed to attend hospital on the due date. Eighty five operations were cancelled because of lack of a bed, nine because of lack of theatre time, and six for medical reasons; 13 admissions were cancelled by patients, and in only 10 was the reason for cancellation not recorded. Of the 630 patients admitted, a further nine had their operation cancelled, five for medical reasons, three because of lack of theatre time, and one because the patient refused to give consent. No cases on which data were available were cancelled because of the lack of availability of a surgeon to conduct the operation.

Although this study was carried out in 1997, there has been no material change in the service provision in most NHS hospitals since. Anecdotally, Southampton University Hospitals NHS Trust is typical of most large teaching hospitals. Lack of beds and theatre time constitute by far the largest reasons for cancellation of planned surgical admission. Increasing the available time of surgeons will accomplish little without a corresponding increase in the number of available bed days and theatre hours. The NHS infrastructure needs urgent attention, not consultant contracts. Whatever the attitude to the desir-

ability of private practice, such practice is unlikely to be a significant cause of long waiting lists in the NHS.

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1 Consultant contract: framework. Available at: www.bma.org.uk/apnsf/Content/_Hub+ccsc+contract (accessed 3 July 2002).

Weak negotiators strike again

EDITOR—I left the NHS two years ago when the morale of consultants was, I thought, at an all time low. We had been rendered essentially powerless by hospital managers, were paid a low salary for our expertise and clinical commitment, and were the victims of continual government spin depicting us as lazy, uncaring, unsafe Bentley-driving moneygrabbers with huge private practices. I was particularly frustrated that our representatives, the BMA, repeatedly failed to assert our real position and always seemed to climb down when challenged by negative spin. I can see now that nothing has changed.¹

This new contract is an appalling deal, and I am astounded that the BMA negotiators consider it a victory. If you offered the equivalent deal to any other professionals, such as barristers or dentists, they would laugh at you. Hospital porters would not accept the extension of the normal working day as proposed in the contract. Some consultants in the middle bracket will actually take a pay cut. The only significant pay rise is the £10 000 for newly appointed consultants, who, in reality, will no longer be able to do any significant private practice as the extra eight hours' commitment to the NHS will prevent it. The £10 000, in fact, is not a pay rise because any consultant doing eight hours a week in the private sector would make far more than £10 000 a year.

The BMA negotiators think that the government has climbed down on the seven year rule for newly appointed consultants when, in reality, consultants' private practice has been restricted for life. Any consultant wishing to pursue private practice will have less time to do so under the new contract. He or she will almost certainly not get the £5000 pay rise every five years that is given at the discretion of hospital managers (who now, more than ever, are the powerbrokers).

In the Republic of Ireland, consultants are represented by a very strong organisation fronted by people who are not medically qualified. They are hard negotiators who are not dependent on merit awards or potential inclusion in the Queen's honours list. Thus they act exclusively on behalf of consultants.

If consultants accept this deal, it is only a matter of time before they will be clocking in and out with the cleaning and catering staff. The new contract is an insult to highly skilled dedicated professionals who have

made significant personal sacrifices to be where they are today.

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1 Hargreaves S. Government makes U turn on private practice ban. *BMJ* 2002;324:1473. (22 June.)

New contract means cut in pay for part time consultants

EDITOR—I have been a consultant for 14 years. I work part time, seven sessions, and participate in a 1 in 4 on-call rota. If I transfer to the proposed new contract I will take an immediate cut in pay of £1000. I will not regain my current salary level until 2006, and it will be 2008 before I recoup my lost earnings. My so called pay rise will begin in 2008-9, an average of 2% per year over the following five years (subject to managerial approval and assuming that there are sufficient funds to afford it. This is the reality of the proposed new contract for me. It seems a long way from the headlines of 22 June.¹

My vote will be a clear no to the negotiating team's proposals. The proposed move to a 40 hour week significantly disadvantages all consultants who work on a less than full time basis. It would seem the negotiating team either forgot we exist or believe we are a low priority group compared with others.

I recommend all consultants who work part time, particularly those who have been in post around four or five years, or more, get out their calculators. You may well find that your negotiators have negotiated a pay cut for you.

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1 Hargreaves S. Government makes U turn on private practice ban. *BMJ* 2002;324:1473. (22 June.)

The negotiating committee should come up with a new agreement

EDITOR—The framework agreement has removed our ability to work in a professional manner and organise activity for the benefit of our patients.¹ The idea of the rigid session during which attendance in the hospital is mandatory means that no activity will be started in future if it might over-run the end of a session. In addition, there will be no stimulus to be efficient and get more done as an early end to the session is now not rewarded. Although this flexibility is abused by a small minority of doctors, the vast majority use it to organise work as efficiently as possible.

Am I to be paid for my meal breaks? If not, I will have to take them as a matter of right as I would be a complete fool if I worked over a lunchtime without being paid. The new contract rewards the clock watcher and treats the doctor who stays until the job is done as an idiot. The only staff left on a professional contract will be managers, and I am afraid I simply do not trust statements

such as "we would never interpret the contract in that way." If it is written down, it can be enforced.

I do not understand why, as a consultant of some 14 years, it will take me 23 years from appointment to reach the salary maximum, whereas a newly appointed consultant would take 19. I wrote to Douglas Bilton, acting secretary of the Central Consultants and Specialists Committee on this matter and was told that this was the best that could be done to bring the deal in under the financial limits imposed. I have no problem with new consultants being awarded a decent salary, but I object strongly to my colleagues and me being discriminated against. We are the group who did a large number of appalling rotas and did not get the salary or time off given to current trainees. Why should we be penalised again? If the contract needs to be phased in, then an equitable scheme for all should be sought.

Although the idea of payment for emergency work and so on out of hours is laudable, sessions to cover onerous on-call commitments have always been negotiable locally. All that has happened so far is that this principle is to be formalised nationally, but with the loss of recognition of the nature of unsocial hours.

We can do much better, and for the good of the service we certainly ought to. The negotiating committee should take this framework back.

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1 Consultant contract: framework. Available at: www.bma.org.uk/apnsf/Content/_Hub+ccsc+contract (accessed 3 July 2002).



Summary of responses

EDITOR—By 3 July 22 respondents had sent us 23 responses to the two news items on the consultants' new contract.^{1 2} Sixteen respondents were scattered throughout England, from Truro to Newcastle; three wrote from Scotland, and one each from Belfast, Dublin, and Jersey. Four were consultants in various subspecialties of anaesthesia or psychiatry, two were consultant physicians, and two were consultants in accident and emergency medicine. The 10 other respondents were from a wide range of disciplines, including academia, radiology, endocrinology, and clinical neurophysiology.

Condemnation of the contract was unanimous.

Graeme Weiner, a consultant otolaryngologist in Exeter, rushed to read the latest on the contract in the *BMJ* of 22 June but was incredulous to find there was none. He suggests the journal commission an article "by a couple of employment law specialists (and perhaps a human rights lawyer) so that we may see how truly awful the proposed framework is."

Others criticised the use of spin in reporting the new contract. Lesley Wilson, consultant old age psychiatrist from Jersey, said that the *BMJ*'s headline was unfortunate and "will tend to support the widely held

view that all that consultants are interested in is keeping their private work.

"Perhaps a better one (though not quite as catchy) would have been: 'BMA submits to government demand that its members work evenings and weekends for standard rate of pay.'"

Indeed, has the BMA, and by extension the *BMJ*, "fallen victim to the government's spin as much as the rest of the media?" asks consultant physician Guy Clifford from Kettering. Both the extension of normal working hours and the effective introduction of performance related pay "are headline news as far as the 26 000 consultants in the UK are concerned, but in your most recent article regarding the new contract, no mention was made of this. Can there be any excuse for such biased and poor reporting of the facts to your own members?"

John Carter, consultant anaesthetist in Chelmsford, agrees that the main problem "is the spin being put on this draft, not by the government (I can live with that), but by my trade union. I do not want the BMA to 'sell' this draft to me. I want the negotiators to go back to the table and get more. The trainees did it. We should too." Change the negotiating team if necessary, he says.

A lack of accountability and clarity also militates against acceptance of the new contract.

Negotiations started off well, points out John Morgan, senior lecturer in psychiatry at St George's Hospital Medical School: "As a public relations exercise, the BMA invited consultants to pose questions concerning the new contract with the welcoming words 'We will attempt to answer all emails individually.'" But when he did so he found that the BMA was "unable to enter into detailed correspondence on an individual basis."

"After such a protracted period of negotiation, the BMA should have placed itself in a position whereby it could answer queries with speed and accuracy. In failing this, fear of the unknown will surely cause us all to vote no."

James Anderson, consultant radiologist in Darlington, would be grateful for further information on what exactly the proposed contract offers in terms of pensions "as this subject seems to be couched in rather vague language" along with the "many clauses preceded by should, usually, and is expected" scattered throughout it.

Finally, consultant anaesthetist Michael Jordan from Ashford, exhorts his fellow consultants to look closely at the hard copy of the framework posted to them in the last week of June: "The cover depicts two prisms bending light in ways that defy the laws of optics. There's a metaphor there somewhere..."

Sharon Davies *letters editor, BMJ*

1 Electronic responses. Government makes U turn on private practice ban. *bmj.com* 2002. (bmj.com/cgi/content/full/324/7352/1473/a#responses; accessed 3 July 2002.)

2 Electronic responses. Juniors call on consultants to reject new contract. *bmj.com* 2002. (bmj.com/cgi/content/full/324/7352/1478/a#responses; accessed 3 July 2002.)

Gold for the NHS

No natural limitation exists on demand for services free at point of supply

EDITOR—By far the most encouraging sentence in Robinson's editorial is the last: "There is a strong case for arguing that ... UK healthcare policy should be driven by the supply side rather than the demand side reform."¹ Yet there is not a word of this from the chancellor or the secretary of state or in the report by Wanless, whose terms of reference guaranteed his conclusions. Even working within those limitations Wanless managed to generate some gratuitous drive, saying that the cost of health care is likely to fall as we take greater measures to improve our health.

There may have been some excuse for Aneurin Bevan's assessment of budgetary realities, but surely 54 years' unvarying experience has been enough to convince us of the truth of another health secretary's assessment (Enoch Powell's): there is no natural limitation on the demand for any good or service free at the point of its supply. Until that is grasped and fully understood, those working in the NHS will continue to be the poorly paid providers of inferior care to an ungrateful public.

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1 Robinson R. Gold for the NHS. *BMJ* 2002;324:987-8. (27 April.)

What exactly is being bought with this gold?

EDITOR—Two concerns came to me when I read Robinson's editorial about the plans for unprecedented rates of growth in NHS spending.¹

The first is, what exactly is the government buying with the extra billions it is spending on the NHS? Is it hoping to buy more medical treatment on behalf of the public? Is it hoping to make the population healthier by so doing?² If it is the first of these then the government has some hope of achieving its aims, although where the extra staff are going to be brought from is not clear. If the government is hoping to make a difference to the overall health of the public by spending through the NHS system it is mistaken. Any treatment system such as the NHS can only deal with the casualties of life, not with how to live healthily in the first place.

This brings me to my second concern: that simply concentrating on supply side measures will pander to medical vanity (treatment as all important) and move thinking away from looking at how and why demand for medical services arises in the first place.

Unless we as individuals and as a society are able to encompass the full picture of health, including its environmental factors, its social relationships, and its political and moral dynamics, we will continue to find

health puzzling and frustrating. We must start to examine the sources of demand for health care and learn to modify them early. This will require courageous medicine and courageous politics.

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1 Robinson R. Gold for the NHS. *BMJ* 2002;324:987-8. (27 April.)

2 Moore W. NHS to receive an extra £40bn over next five years. *BMJ* 2002;324:993. (27 April.)

Postcode prescribing is alive and well in Scotland

EDITOR—We had understood that one of the intentions of the National Institute for Clinical Excellence (NICE) was to rationalise the introduction of new drugs and technologies across the United Kingdom so that NHS patients would have equitable access. This has plainly not happened. We illustrate the problem with three recently licensed drugs, imatinib, irinotecan, and trastuzumab.

Imatinib has yet to be appraised by the National Institute for Clinical Excellence, but our local haematologists completed the paperwork for approval by Lothian Health Board's drug evaluation panel. The drug was not approved. Shortly afterwards the Scottish Medicines Consortium issued guidance to indicate that it should be made available: we await the result of an appeal to the drug evaluation panel. Meanwhile patients in Fife can get it.

Irinotecan was approved by the National Institute for Clinical Excellence and the Health Technology Board for Scotland. However, the drug evaluation panel for Lothian has rejected it—despite knowing the decisions of the institute and the board—on the grounds that the improved survival does not justify the cost. If the patients live in the west of Scotland, however, they can receive it. In Aberdeen doctors are allowed to prescribe it but without any additional funding, so that expenditure on irinotecan competes with that on other drugs.

Trastuzumab was approved by the institute after a year's deliberation, and then by the Health Technology Board for Scotland. It is already available in the west of Scotland; but recognising that the real decision about its availability in the east of Scotland lies with the Lothian Health Board, we have to carry out a detailed assessment of the total cost before applying to the drug evaluation panel. The only reason we have any optimism about its decision is that some funding may already have been identified.

The current system seems no more equitable than previously; extra layers of central committees exist, and drug availability continues to depend on local health board decisions. We would advocate a streamlined approach, with centralised decision making bodies such as NICE and the Scottish Medicines Consortium. Any deci-

sion in favour of a new drug should result in automatic top-sliced funding going direct to the departments dispensing the drugs, so that clinicians do not have to apply locally for approval and funding.

The alternative is a return to the old system of postcode prescribing. This, however, would require politicians to acknowledge that local health boards have the right to set different priorities and are prepared to take the clinical consequences of their decisions.

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vCJD: the epidemic that never was

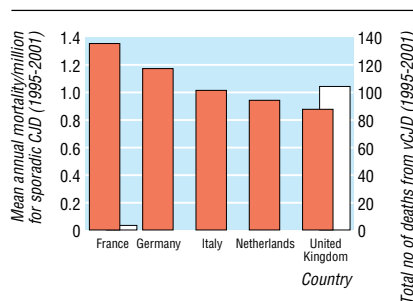
New variant Creutzfeldt-Jakob disease: the critique that never was

EDITOR—Venter's article on new variant Creutzfeldt-Jakob disease (vCJD) is intended to stimulate debate, which we hope will be better informed than the article itself.¹

Is variant Creutzfeldt-Jakob disease a new disease? Venter places great emphasis on Creutzfeldt's case, but this patient did not have Creutzfeldt-Jakob disease. The illness was characterised by gait disturbance, a relapsing and remitting course, nystagmus, and status epilepticus. These are not the clinical features of variant Creutzfeldt-Jakob disease and, crucially, the neuropathological appearances were "not characteristic of Creutzfeldt-Jakob disease."²

In 1996 confidence in the novelty of variant Creutzfeldt-Jakob disease was based largely on the identification of a neuropathological phenotype that was distinct from that experienced in the United Kingdom from 1970. Since then archival tissues have been reviewed in many countries and no past cases with a similar neuropathological pattern have been found.³ Retrospective epidemiological surveys in England and Wales have not identified any missed cases of variant Creutzfeldt-Jakob disease from 1979-96.⁴ Current evidence strongly supports the hypothesis that variant Creutzfeldt-Jakob disease is indeed a new disease.

Was variant Creutzfeldt-Jakob disease identified solely because of improved surveillance? There was a doubling in the annual death rates for sporadic Creutzfeldt-Jakob disease in the United Kingdom between the 1980s and the 1990s, but similar increases in the apparent death rates for sporadic Creutzfeldt-Jakob disease had occurred in other European countries.⁵ These countries have been subject to similar potential improvements in case identification, but variant Creutzfeldt-Jakob disease remains a disease occurring predominantly in the United Kingdom, despite significant



Death rates for sporadic Creutzfeldt-Jakob disease and total numbers of deaths from variant Creutzfeldt-Jakob disease by country

numbers of young suspect cases being investigated in each country (figure).

Venter argues correctly that the curve for the epidemic of variant Creutzfeldt-Jakob disease does not parallel the number of cattle with bovine spongiform encephalopathy (BSE) between 1983 and 1988. However, human exposure to the BSE agent almost certainly extended to 1996 and depended on a range of variables not addressed by his model. These include the species barrier between cattle and humans, the numbers of cattle in the final year of the incubation period, the load of bovine central nervous tissue entering the human food chain, the efficiency of legislative measures, and temporal changes in food production. Extrapolation from conventional foodborne epidemics to epidemics of variant Creutzfeldt-Jakob disease and BSE is clearly too simplistic.

A wealth of laboratory evidence supports the hypothesis that the BSE agent is the cause of variant Creutzfeldt-Jakob disease.⁶ Venter states correctly that there is no direct evidence that the BSE prion is infectious to humans, but obtaining such evidence would be difficult to justify ethically as this would involve inoculating humans with the agent. A judgment on the link between BSE and variant Creutzfeldt-Jakob disease inevitably depends on an assessment of a range of clinical, pathological, epidemiological and laboratory based evidence. There is now overwhelming evidence that BSE is the cause of variant Creutzfeldt-Jakob disease, although there remain uncertainties about the future number of cases and the mechanism of transmission of BSE to humans.

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1 Venter GA. New variant Creutzfeldt-Jakob disease: the epidemic that never was. *BMJ* 2001;323:858-61.

2 Richardson EP, Masters CL. The nosology of Creutzfeldt-Jakob disease and conditions related to the accumulation of PrP^C in the nervous system. *Brain Pathology* 1995;5:33-41.

3 Budka H, Dormont D, Kretschmar H, Pocchiari M, van Duijn C. BSE and variant Creutzfeldt-Jakob disease: never say never. *Acta Neuropathol* 2002;103:627-8.

4 Majeed A, Lehmann P, Kirby L, Knight R, Coleman M. Extent of misclassification of death from Creutzfeldt-Jakob

disease in England 1979-96: retrospective examination of clinical records. *BMJ* 2000;320:145-7.

5 Will RG, Alperovitch A, Poser S, Pocchiari M, Hofman A, Mitrova E, et al. Descriptive epidemiology of Creutzfeldt-Jakob disease in six European countries, 1993-1995. *Ann Neurol* 1998;43:763-7.

6 Zeidler M, Ironside JW. The new variant of Creutzfeldt-Jakob disease. *Rev Sci Tech Off Int Epiz* 2000;19:98-120.

Creutzfeldt's patient did not have Creutzfeldt-Jakob disease

EDITOR—Venter uses Creutzfeldt's original case report of 1921 as an argument against the existence of a "new" variant of Creutzfeldt-Jakob disease (CJD).¹ Creutzfeldt described a patient who presented to his department aged 23.

She was the youngest of five children, two of whom had mental retardation. The patient's parents were both dead, the cause or date of the father's death was not known, the mother had died of a "non-neurological" disease when the patient was 14. In her late adolescence, the patient was thought to be odd, as she continued to play with dolls and exhibit other childlike behaviour. Aged 21, she refused to eat, claiming that she wanted to lose weight. At the same time, her gait was noted to be "heavy." Aged 22 she developed a symmetrical rash affecting her face, later also both hands, her groin, and both feet. She was found to have spastic legs and tremor in all limbs. While on a dermatology ward she had a "hysterical seizure" with arc de cercle. It is not clear how she was treated, but all of her symptoms, including the gait disorder, improved.

One year later the gait deteriorated again. At the same time the patient refused to eat or wash, complained about chest pains, and exhibited agitated and paranoid behaviour or inappropriate laughter. On admission to the neurology department she was pyrexial at 38.9°C, incoherent and not oriented in time or space. Her speech had a staccato quality. She had myoclonic limb jerks, intention tremor, nystagmus, increased limb tone, brisk tendon jerks, hyperaesthesia, and hyperalgesia. She gradually deteriorated over three months and died in status epilepticus characterised by tonic seizures, seizures with Jacksonian march, and clonic jerks.

From a clinical point of view, family history, relapsing course, and skin rash would argue against a diagnosis of "variant" or sporadic Creutzfeldt-Jakob disease. More importantly perhaps, Creutzfeldt's meticulous histopathological report does not mention spongiform change (conspicuous in almost all known cases of Creutzfeldt-Jakob disease) or florid plaques (one of the hallmarks of variant Creutzfeldt-Jakob disease).² Creutzfeldt's original pathology slides were reviewed by Jakob who thought the changes were identical to those seen in two of his own patients.^{3,4}

The tissue from Jakob's two patients was reviewed by the neuropathologist C L Masters in 1982, who found that these patients of Jakob's did not have any evidence of a spongiform encephalopathy. Only his later patients had changes typical of Creutzfeldt-Jakob disease.⁵ The first two

patients certainly did not have new variant Creutzfeldt-Jakob disease. Perhaps we should drop the "C" from Creutzfeldt-Jakob disease.

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- 1 Venters GA. New variant Creutzfeldt-Jakob disease: the epidemic that never was. *BMJ* 2001;323:858-61.
- 2 Creutzfeldt HG. Ueber eine eigenartige Erkrankung des Zentralnervensystems. *Z ges Neurol Psychiat* 1920;57:1-18.
- 3 Jakob A. Ueber eigenartige Erkrankungen des Zentralnervensystems mit bemerkenswertem anatomischem Befunde (Spastische Pseudosklerose-Encephalomyelopathie mit disseminierten Degenerationsherden). *Z ges Neurol Psychiat* 1921;64:147-228.
- 4 Richardson EP, Masters CL. The nosology of Creutzfeldt-Jakob Disease and conditions related to the accumulation of PrP^{Sc} in the nervous system. *Brain Pathol* 1995;5:33-41.
- 5 Masters CL, Gajdusek DC. The spectrum of Creutzfeldt-Jakob disease and the virus-induced subacute spongiform encephalopathies. In: Smith WT, Cavanagh JB, eds. *Recent advances in neuropathology*. Edinburgh: Churchill Livingstone, 1982:139-63.

Possibility of BSE being cause of variant CJD is indeed biologically plausible

EDITOR—Venters argued against bovine spongiform encephalopathy (BSE) causing variant Creutzfeldt-Jakob disease.¹ In fact, the biological plausibility of this being the cause, the strength of the epidemiological association, and the experiments indicating that the same prion is involved are all good.

Incubation periods for BSE are proportional to the life expectancy of the animal affected. The disease's incubation period is 18% of a cow's life expectancy and would be expected to about double when crossing to another species—that is, to 36% of 70 years in humans. Thus the incidence of a disease due to BSE in humans would be predicted to peak in 2014. A few human cases would be seen before 2000 and none early in the 1990s. Small outbreaks would be expected early in the epidemic before they become lost among a high background prevalence.² The pattern of variant Creutzfeldt-Jakob disease cases fits this.

Everyone in the United Kingdom has eaten on average over 50 meals of the tissues of cattle infected with BSE; this figure would be lower in other countries. The novelty of variant Creutzfeldt-Jakob disease is not now questioned as it is different from kuru on histopathological grounds and scrapie prion (PrP^{Sc}) biochemistry. No similar cases before 1995 have been found.³

BSE infects a different range of animals from scrapie and infected all the species inoculated experimentally except chickens and hamsters. It is reasonable that it might infect humans. When fed BSE, 25% of sheep, 33% of goats, 50% of kudu, 100% of mice, and 100% of mink died. Calculating this percentage for humans is difficult as it is early in the epidemic.²

BSE prion doses to which humans may have been exposed might well cause large numbers to become infected despite the inefficiency of the oral route. Beef exported from the United Kingdom to France was mainly older animals, specific tissues, and calves. This means that there was a relatively high dose of prions per meal in France, and

this fits the number of cases of variant Creutzfeldt-Jakob disease seen there.² Why younger people are apparently becoming infected is not clear, but this does not mean that BSE is not the cause.

Identical pathology and PrP^{Sc} glycoforms are produced in mice when variant Creutzfeldt-Jakob disease, BSE, or feline spongiform encephalopathy is inoculated. This is exceptional evidence that the same prion is the cause.⁴ PrP^{Sc} associated with BSE will alter human normal prion protein to the abnormal form *in vitro*,⁵ but it is not surprising that transgenic mice expressing human prion protein did not become infected easily with BSE.

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Author has overlooked several findings that support his argument

EDITOR—Venters's reappraisal of variant Creutzfeldt-Jakob disease (vCJD) is important¹ because, even if new cases of the disease continue to be reported sporadically or in an occasional cluster, there is no evidence of an epidemic anywhere.² But in dismissing the misfolded prion glycoprotein that "causes" bovine spongiform encephalopathy (BSE) as the cause of variant Creutzfeldt-Jakob disease in humans Venters overlooks other findings that support his argument.³

Firstly, BSE began in dairy herds in 1986, almost immediately after the Ministry of Agriculture, Fisheries and Food removed controls on foodstuffs for cattle and mandated supplementary feeding with proteinaceous offal, often containing scrapie material, to increase milk production.

Secondly, suckler-fed, grass-fed pedigree herds were virtually unaffected unless they were in contact with dairy cattle.

Thirdly, BSE subsided when supplementary feeding with proteinaceous offal was banned.

Fourthly, ascertainment of unprecedented intensity has shown an excess of all five forms of Creutzfeldt-Jakob disease in the United Kingdom since 1989 but no excess of variant Creutzfeldt-Jakob disease in those at high, continuous, and percutaneous risk of occupational exposure to actual BSE—namely, veterinarians, and people working on farms and in cattle markets, abattoirs, butchers' shops, and canteens.

Fifthly, the same ascertainment has identified variant Creutzfeldt-Jakob disease

in younger people with questionable levels of presumed exposure from ingestion of cooked beef or beef products possibly containing BSE prion. An increase in incidence, from 0.8 confirmed cases per million in 1995 to 1.2 in 2000, is continuing, along with an overall increase in total (including iatrogenic) referrals but a decrease in all other forms of Creutzfeldt-Jakob disease. Surveillance of relevant neurological disease in children in the United Kingdom since 1997 has yielded only three cases, although suspect prion is present in tonsils.

Prusiner and his team give reasons for regarding scrapie prion as the common cause of BSE.⁴ But there are genetic and other reasons, as above, for questioning the hypothesis that BSE is directly transmissible to humans. Although published as a witness statement in the BSE enquiry,⁵ these reasons were not discussed in the ensuing (Phillips) report, which preferred to conclude that BSE originated as a mutant of scrapie prion in the 1970s.⁶ It was content to accept common causation on the basis of endpoint similarities in neuropathological features of variant Creutzfeldt-Jakob disease and BSE, as observed in cattle and in transgenic mice bred with the gene for BSE prion and then inoculated intracerebrally with brain material from cattle with BSE.

Factual evidence about the revolution in animal feeding and the nil incidence of variant Creutzfeldt-Jakob disease in close human contacts at highest risk is giving way to artefactual experimental results in mice supporting a hypothesis that BSE prion can cross a further species barrier to cause variant Creutzfeldt-Jakob disease in humans.^{2,3,5,6} This is the scientific hypothesis now used to maintain speculation that anyone who eats British beef or beef products has a lifetime risk—at present, 1.2-1.5 per million persons per annum^{2,6}—of developing variant Creutzfeldt-Jakob disease and starting an epidemic.

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Has medicalisation of childbirth gone too far?

Regional analgesia in labour permits childbirth without fear

EDITOR—Several points in Johanson et al's review on the medicalisation of childbirth deserve comment.¹ Firstly, maternal mor-

tality related to anaesthesia has declined dramatically over the past few decades. Recent surveys from both the United Kingdom and the United States find that the few fatal complications of anaesthesia in obstetrics are usually related to complications of general anaesthesia—for example, loss of airway or hypoxia.^{2,3}

The decline in the use of general anaesthesia for caesarean delivery must partly be attributed to the rise in use of regional analgesia during labour.⁴ In fact, the American College of Obstetricians and Gynecologists has issued a statement saying: "Failed intubation and pulmonary aspiration of gastric contents continue to be leading causes of maternal morbidity and mortality from anesthesia. The risk of these complications can be reduced by careful antepartum assessment to identify patients at risk, greater use of regional anesthesia when possible, and appropriate selection and preparation of patients who require general anesthesia for delivery."⁵

Johanson et al's paper states that women are "encouraged" to receive epidural analgesia in labour. This paternalistic attitude ignores the fact that most women in labour choose epidural analgesia of their own volition, without influence. I believe firmly that the choice for women to elect to undergo natural childbirth should always be available (within the limits of safety with regard to certain high risk conditions), just as some of us choose to climb mountains or run marathons. This should also be accompanied by the attitude among all obstetric and anaesthetic care providers that there is nothing "wrong" with women who choose natural childbirth.

But most people do not run marathons or climb mountains. And most women do not want to have pain during childbirth. The widespread use of regional analgesia in labour should be celebrated as one of the blessings of having a baby in this millennium. Pain free childbirth has become as much a part of modern culture as the mobile phone or the microwave oven.

Johanson et al state that "Childbirth without fear should become a reality for women, midwives, and obstetricians." As one of the cardinal fears of labour is pain, the widespread availability and use of regional analgesia should go a long way towards reducing this fear.

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Timely intervention is the key

EDITOR—Johanson et al imply that medicalisation of childbirth has led to a high caesarean section rate and quote data from Catalonia to Ontario.¹ They have forgotten their neighbours in the Republic of Ireland, where active management of labour is practised in some units.² The National Maternity Hospital in Dublin, for instance, boasts a section rate that has been consistently among the lowest in developed nations.

Strict criteria for the diagnosis of labour, early amniotomy, use of oxytocin, and the involvement of a senior obstetrician at an early stage are cornerstones of the active management of labour. In addition, units in Dublin believe strongly in patient choice, and epidural analgesia is widely used. Do Johanson et al not consider these interventions to be medicalisation?

Active management of labour was designed primarily to reduce morbidity (and mortality) associated with prolonged labour—something that most obstetricians of the present generation seem to have forgotten about. One of the side effects of the active management of labour is a reduction in the caesarean section rate.

Surely the authors must accept that some of the reasons why the United Kingdom has a high section rate has to do with the fact that we don't know how to diagnose labour (ask any midwife or obstetrician and you will get a myriad of responses) and we don't know when to perform an amniotomy, use oxytocin, or involve a senior obstetrician.

No, the problem isn't that the medicalisation of childbirth has gone too far; rather, it's that we don't know when to intervene. We agree with the authors that visits to other units and countries should be encouraged. More of us should travel across the Irish Sea.

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Childbirth in Taiwan is certainly overmedicalised

EDITOR—Taiwan has transformed itself from a developing to a developed country in recent decades.¹ As it has done so, medical resources have improved dramatically and now compare favourably with those of any Western industrialised nation.

Alas, in childbirth, medicalisation has taken hold throughout the obstetric profession. Nearly every intervention in childbirth is perceived as necessary and good. For example, on entering a delivery suite pregnant women undergo a routine enema, routine pubic shaving, routine nil by mouth, routine intravenous cannulation, and routine intravenous hydration. The paternalistic approach is the norm.

Pregnant women at term with rupture of membranes before labour are subjected to routine induction of labour. Again, the paternalistic approach offers no choice. Expectant management for even the next 12-24 hours is perceived as too risky an alternative. Even pregnant women at 36 weeks' gestation are subjected to the same routine protocol.

All women in labour undergo routine midline episiotomy. Every woman is subjected to this regardless of gestation (term or preterm). The episiotomy rate approaches 100%.

The above practices are so entrenched that any change of practice would meet much resistance. Increasing medicalisation has led not to diminishing but to increasing numbers of medicolegal cases. A vicious cycle ensues. Obstetricians now act and intervene even more for fear of litigation.

Government health statistics show that the number of registered midwives declined in the past decade, from 1891 in 1990 to a mere 558 in 2000. During the same period the number of registered doctors rose from 19 921 in 1990 to 29 585 in 2000. This is for a population of 20 million in 1990 and 22 million in 2000.²

As Taiwan now seeks observer status in the World Health Organization, professional bodies and governments in Taiwan should promote obstetric practice as contained in the WHO report *Care in Normal Birth: A Practical Guide*, which aims at improving obstetric practice in normal childbirth.³

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Evolving general practice consultation in Britain

Increasing consultation time may not be straightforward

EDITOR—Freeman et al plead for longer consultations in British general practice.¹ A pilot study performed with six general practitioners in Glasgow shows that breaking the habit of short consultations may be difficult and longer consultations may lead to higher health service costs.

Our study piloted a randomised controlled trial of the effect of an increased booking interval on identification of the patient's psychological distress.² Each doctor's surgery was randomised to either 10 minutes per patient (the normal booking interval) or 15 minutes. One of us (MS) offered locum sessions to make up the shortfall in available consultations. We recorded 65 consultations at each booking interval for each practitioner. After the consultation, patients

completed the general health questionnaire-12; doctors estimated psychological distress using a six point scale and recorded important outcomes of the consultations. Consultations were timed by a research assistant.

Data were collected from 781 consultations. When booking interval was increased by 50% consultation length increased by 12%, from 8.7 minutes to 9.7 minutes. Longer booking intervals significantly increased the number of consultations in which the doctor arranged investigations (19.4% *v* 27.9%; $P=0.0069$) and follow up appointments (43.8% *v* 53.7%; $P=0.0072$). There was no significant effect on the proportion of consultations in which prescriptions were issued (51.0% *v* 54.7%; $P=0.34$), physical examination carried out (66.8% *v* 66.8%; $P=0.96$), or referral made (14.0% *v* 10.7%; $P=0.20$).

There were no significant differences in identification of psychological distress between long or normal booking intervals (odds ratio 1.00 (95% confidence interval 0.63 to 1.59)).

Although booking interval increased by 50%, consultation length increased by only 12%. This raises the question of what the doctors did with the extra time. It has been argued that increasing the length of consultations will save time and resources. Our results suggest that the opposite is true; doctors ask more patients to make follow up appointments after longer consultations and perform more investigations. Perhaps doctors given more time with patients simply uncover more problems. The lack of impact of an increased booking interval on the recognition of psychological distress in patients suggests that structural constraints are insufficient to explain low rates of recognition of distress by general practitioners.

Our results must be interpreted with caution. A more sustained intervention might have led to more major changes in consulting behaviour. Our data suggest, however, that longer consultation intervals may cost more than remuneration for extra general practitioners' time.

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Longer consultations might necessitate redeployment of pharmacists

EDITOR—Freeman et al open an overdue debate about the length of consultation times.¹ They address the question of why consultations should be longer but do not consider how this might be achieved.

The workload in primary care is increasing faster than the workforce is. This is

fuelled partly by demography, partly by increased health expectations, and partly by developments in treatment. The unremitting commercial gamesplaying of the pharmaceutical industry, highlighted in an article in the same issue of the *BMJ* as Freeman et al's article, adds another turn to this screw.²

General practitioners are fully occupied. There is no prospect of a huge increase in the general practitioner workforce in the next decade. The only way for doctors to have more time is therefore for them to stop doing things.

There are a few activities that general practitioners might simply stop doing. Some may need legislative change, such as a move from repeat prescribing to repeat dispensing.³ This would probably save the average general practitioner about an hour a day. Other changes might need us to question some of our routine behaviours perpetuated by the convoluted fee structure of general medical services. Why do we need to see patients taking contraceptives twice a year? Why do we still dabble in antenatal care when midwives do it so much better? What is a "full postnatal examination" for?

The most effective way of freeing up time is to delegate. Get someone else to do it—preferably someone who is better at it than you are. The extended roles of practice nurses and nurse practitioners are a move in this direction, but there are so many calls on nurses that we are probably close to the limit of available staff. The largest untapped source of underused skill, however, is community pharmacists: the fact that so many are trapped behind their counters selling baby food and offering cold remedies of questionable efficacy is a waste of their clinical skills.

The future of the traditional high street pharmacy is threatened by the pincer movement of industrialised warehouse dispensing and the supermarket pharmacy. At present supermarket pharmacies are contributing to a manpower shortage, but warehouse dispensing could reverse this trend. The potential exists to redeploy pharmacists into general practices to review patients and supervise drugs, making best use of their knowledge and developing skills.^{4,5} This would free up general practitioners and enable them to extend consultations and improve the depth and breadth of care.

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The lot of airline pilots and consultants is not so different

EDITOR—A day in the life of a hospital consultant: is it so different from that of an airline pilot?¹ Awake from a restless night. Study the latest directive from the flying tsar. Finish off writing lecture notes on emergency landing procedures. Set off to airport via a charity coffee morning to receive cheque to buy a new pilot seat.

Arrive Stansted. Pilots' car park full of ground crews' cars, so have to park some way away and walk to check-in.

Take morning flight to Paris. Mid-channel find out that there is only one trained air steward in the cabin and the rest are steward assistants; go back to help. Standing room only because of 30 over-bookings.

Land; sprint across tarmac and take 9 am flight to Copenhagen. During flight do two appraisals of navigators, answer 10 written complaints about cuisine, and lecture flight staff about latest safety procedures.

Land at Copenhagen. Race across tarmac and take 11 15 am flight to Brussels. Land 1 pm on two sets of wheels as one set now 15 years old (application to lottery fund for new set failed). Receive round of applause for good landing and a writ from a passenger whose duty free goods fell on his head.

Take flight to Athens. Co-pilot is new style trainee with 10 minutes' flying experience. During flight talk down two other landings because staff are inexperienced.

Arrive Athens 3 pm. Immediate turnaround. Flight back to London Stansted 7 pm. Find car wheel clamped. No problem as bleep went off and I had to take emergency cargo flight to Glasgow. Big bonus: I was able to wave goodnight to the children as I flew over the house. Arrive Glasgow in the early hours of the morning; canteen shut so grab stale sandwich from vending machine and try to grab an hour's sleep in airport terminal chair.

Still, it was better than yesterday.

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